

Alaska Medicaid
Suboxone®/Subutex®
Prior Authorization Request Form
Prescriber Use Only



Fax this request to: (888) 603-7696

Questions? Call Magellan Medicaid Administration at (800) 331-4475

Or mail this request to: Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043

Form available: <http://www.hss.state.ak.us/dhcs/pharmacy/medpriorauthoriz.htm>

Note: Suboxone®/Subutex® Product PA's can only be requested using this form.

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

Revised 7-2011

REQUESTOR	Must be requested by prescriber. See below.	
RECIPIENT	Last Name, First Name, Middle I.:	
DOB: <small>mm/dd/yyyy</small>	Medicaid ID: <small>(10-digits)</small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
PRESCRIBER	Name:	NPI: <small>(10-digits)</small>
Phone: ()		Fax: ()
Specialty:		DEA #
REQUEST	Doses > 3 units per day OR 24 mg per day will NOT be approved.	
	Only 1 strength of 1 product will be authorized for use at a given time. Check one Box	
<input type="checkbox"/> Suboxone® SL Tab 8mg/2mg <input type="checkbox"/> Suboxone® SL Tab 2mg/0.5mg <input type="checkbox"/> Suboxone® SL Film Tab 8mg/2mg		
<input type="checkbox"/> Suboxone® SL Film Tab 2mg/0.5mg <input type="checkbox"/> buprenorphine SL Tab 8mg <input type="checkbox"/> buprenorphine SL Tab 2mg		
Quantity _____ Sig _____		
RATIONALE FOR PRIOR AUTHORIZATION		Prior Authorization start date:
Primary Diagnosis: ICD-9 _____		
Check all that apply:		
<input type="checkbox"/> The patient is at least 16 years old.		
<input type="checkbox"/> The patient is being treated for opioid dependence and has agreed to adhere to a treatment plan.		
<input type="checkbox"/> The physician meets all qualifications (State and Federal) to prescribe buprenorphine products for treatment of opioid addiction.		
<input type="checkbox"/> The physician has explained the risks of using buprenorphine products with benzodiazepines, alcohol, tranquilizers and narcotic analgesics to the patient.		

PHYSICIAN'S SIGNATURE	DATE	PRESCRIBER'S DATA 2000** WAIVER DEA #

**Drug Addiction Act of 2000

***** All sections must be completed or the request will not be approved*****

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